Modern Concepts of Cardiovascular Disease

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THE ROLE OF THE PHYSICIAN IN EDUCATION OF THE CARDIAC PATIENT

The economic, social and emotional adjustment of the patient with heart disease is sometimes neglected by the private physician and the cardiac clinic. Every cardiac patient must successfully maintain a relationship with his family, his job, his environment, and at the same time live within the limitations of his cardiac capacity.

The first step in management of the patient with heart disease is evaluation of the circulatory status. The Criteria Committee of the New York Heart Association has established a standard nomenclature and criteria for diagnosis[1] of diseases of the heart. This includes etiological, anatomical, and physiological diagnoses and the functional capacity and therapeutic classification.

The functional capacity is an estimation of the patient's ability to perform physical activity.* The therapeutic classification is the physician's opinion of the amount of physical activity the patient may safely do and is a guide in the management of the patient**: The functional capacity and the therapeutic classification are not necessarily the same.

This method of diagnosis and classification is an excellent starting point, but it does not go far enough. The entire life situation of the patient must be assessed in terms of his cardiac status. Often the physician's instructions are either inadequate or impossible to follow. Advice may range from "do everything" to "don't even lift an ashtray." Both statements are meaningless because they lack a frame of reference for the patient.

Patients with heart disease can and do work. Studies have shown that patients with a functional capacity and therapeutic classifications up to and including III C have worked successfully for many years[2]. The average patient appears to be limited more by his age, his emotional disturbances, and the lack of guidance than by his cardiac capacity.

The personality of the patient must be taken into consideration in discussing a detailed prescription for activity. An obsessive-compulsive type is apt to follow instructions over-meticulously and should be given leeway. The activity program for an individual who has a high threshold for pain and fatigue should be understated. The cardiac status and the physical restrictions should be minimized for a patient who is prone to fear and anxiety. The patient who is inclined to disregard advice and suggestions should be put on a specific regime.

During or immediately after an acute cardiac episode, such as a coronary occlusion, an attack of congestive heart failure, or a bout of acute rheumatic fever, a guarded short range program should be formulated. The patient must receive reassurance that this minimal activity program is only temporary. At this time, no definite predictions about future occupation, recreation, and family life should be made.

The physician's aim is to establish rapport and allay anxiety. The patient's reaction to the short range program serves as a guide in planning the long range activity program which is to be established after the cardiac status has become relatively stationary.

There is little necessity to explain the anatomy and physiology of the heart lesion in detail unless the patient so requests. When such a request is made, an analogy in terms of the patient's usual experience is best. A coronary occlusion may be related to a block in the feed line of a motor car. A car functioning on four cylinders instead of eight is a good analogy for a patient with valvular heart disease. Women do not inquire about the mechanics of heart disease as frequently as do men.

After recovery from the acute episode, an appraisal of the physical capacity should be made in terms of the patient's job and daily routine.*** Details about the cardiac status should be underemphasized in favor of details about energy expenditure on a job, traveling time to and from work, family life, hobbies, and recreation.

Frequently the patient may return to his former job either full-time or on a limited basis. If, in the opinion of the physician, a change of occupation is necessary, suitable jobs should be suggested. Referral to a rehabilitation agency for retraining or placement may be necessary. The local Heart Associations will furnish the names of agencies and training schools in their areas. In many communities, the United States Employment Service has a division for the placement of handicapped individuals.

Long range predictions about activity should not be completed in one session. A patient should not receive more information than he can comfortably assimilate at one sitting. At each visit one or two

*Functional Classification of Patients:
Class I: No limitation of physical activity.
Class II: Slight limitation of physical activity.
Class III: Marked limitation of physical activity.
Class IV: Unable to carry on any physical activity without discomfort.

**Therapeutic Classification of Patients:
Class A: Physical activity need not be restricted.
Class B: Ordinary physical activity need not be restricted but should be advised against unusually severe or competitive efforts.
Class C: Ordinary physical activity should be moderately restricted and more strenuous habitual efforts should be discontinued.
Class D: Ordinary physical activity should be markedly restricted.
Class E: Complete rest, confined to bed or chair.

***A chart of physical capacity evaluation may be obtained by writing the New York Heart Association, 2 East 103rd Street, New York.

aspects of his daily living adjustment may be discussed. The frequency of regular check-ups may, in itself, be used as a therapeutic agent. An elderly dependent individual with arteriosclerotic heart disease needs frequent visits for reassurance and guidance. Such individuals may experience a feeling of rejection if given too long an interval between visits. A patient with inactive rheumatic heart disease or a healed myocardial infarct, however, may receive a tremendous emotional lift when told that the intervals between visits may be lengthened. A young man with inactive rheumatic heart disease, mitral insufficiency and stenosis, regular sinus rhythm, classified as II B, should be encouraged to go about his business. Weekly or monthly visits to the physician will only prolong a feeling of invalidism and insecurity.

After a decision about occupation has been reached, the family life, personal habits, and recreational activities must be discussed in terms of the patient's cardiac status and functional capacity.

When outlining an activity program, contradictory statements should never be made to the patient or to his family. Close relatives should be cautioned against nagging and overprotection of the patient. The family should be warned that attempts to force the patient into a regime he is incapable of following will do more harm than good.

The physician, by the same token, should not interdict any activity which the patient will be forced to continue despite the prohibition. Telling a II C cardiac patient who is the only support of a wife and two small children that he must not work, will only create problems. The patient is forced to return to work despite the physician's disapproval and the conflict between the advice and the actuality will produce anxiety. Environmental limitations and emotional concepts, such as attitudes towards pregancy and sex, that cannot be changed, must be accepted by the physician and the family.

The housewife with heart disease presents a special problem. It has been shown that managing a household without assistance is the physical equivalent of a full-time industrial job[3]. The average woman with heart disease cannot be expected to stop housework completely. It is relatively easy, however, for her to limit her time and change her work methods so that the same results are obtained with a minimum of physical exertion. Practical ways of limiting housework should be pointed out by the physician. The booklet "The Heart of the Home" outlines methods of work simplification[4].

The adjustment problem of the young man with rheumatic heart disease differs from that of the middle-aged or elderly person with hypertensive or arteriosclerotic heart disease. The young person, despite diminished cardiac reserve, looks to the future and can usually cope with changes in environment. He can be directed toward a permanent occupation in which he can limit himself when necessary and where his services will remain in demand. Arrangements can be made for training in new job techniques. His social and recreational habits can be changed without emotional trauma.

The middle-aged person with hypertension is often faced with the problem of the past. Drastic reorganization in his way of life is emotionally undesirable. He must be limited within the framework of his usual living standard. The same occupation, the same environment, the same recreational habits must be maintained, but limited as to time and energy expenditure.

If a cardiac is classified as possible and potential heart disease[1], or class I A he must be told emphatically that limitation of activity is not necessary.

If a patient is found to have an unexplained (functional) murmur[1], an unequivocal statement must be given that no heart disease is present; that a functional murmur is a normal phenomenon; that no physical limitation of any sort is necessary. The statement "You have a little murmur. It doesn't mean a thing, but be a little careful" may be dangerous and misleading.

If a patient has a cardiac neurosis a positive explanation is in order that there is no heart disease; that there need not be any limitation of activity; that the symptoms are not referable to the heart. Patients with a cardiac neurosis superimposed on organic heart disease are common. Physical capacity and work tolerance should be evaluated in terms of the symptoms due to the organic lesion. The patient must be advised that some of his complaints are due to anxiety about his heart and conflicts in his life situation rather than to a cardiac lesion. By reassurance and guidance the physician can often do much to allay anxiety and help the patient make a more comfortable adjustment.

At all times, the physician must guard against incomplete explanations, overstatement and understatement, and projection of unproven theories onto the patient. For example, a physician particularly interested in blood pressure fluctuations may make several determinations at each visit and never explain to the patient that there is nothing particularly unusual about his blood pressure. Overemphasis on one aspect of the history, physical examination, or laboratory findings tend to create anxiety unless adequate explanation is given. Discussion of one aspect of the heart disease with an associate in the presence of the patient, causes unnecessary fear and speculation.

Rehabilitation studies have shown that anxiety about the state of his heart is one of the chief factors which prevents cardiac patients from working. Work tolerance increases as anxiety is overcome[5]. The physician in his personal relationship with the patient can do much to prevent the development of anxiety.

Summary

1. The emotional, social, and economic adjustment of the cardiac patient is as much the physician's responsibility as the diagnosis and therapy.

2. Heart disease patients with a functional capacity and therapeutic classification up to and including III C can and do work. The physician must give advice about the amount and type of employment and recreation.

3. Expressed and unexpressed attitudes on the part of the physician or the family may cause the patient anxiety. These include: advice impossible to follow, blanket statements for or against activity, over-protection, nagging, over-emphasis on one aspect of the heart disease, and contradictory statements.

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